Department of Health Care Services
Third Party Liability and Recovery Division
Recovery Section—Personal Injury Unit
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425

MEDI-CAL LIEN REFERRAL
(PERSONAL INJURY CASE)

Source (check one)

☐ Attorney ☐ Insurance Co. ☐ Other:

(DHCS Use) ☐ Inquiry Letter _____Initials

1. INJURED PERSON (Include Aka's)

2. DATE OF INJURY	3. SOCIAL SECURITY NO.	4. MEDI-CAL NO.	5. DATE OF BIRTH
ADDITIONAL INJURED PERSON			
ADDITIONAL INJURED PERSON			

6. TYPE OF INJURY

☐ Auto ☐ Slip and Fall ☐ Malpractice ☐ Other:

NATURE OF INJURY (Body Parts Injured)

Still being TREATED? ☐ Yes ☐ No

LAST DATE OF TREATMENT

7. DENTAL SERVICES ☐ Yes ☐ No

8. INJURED'S ATTORNEY / NAME OF FIRM

TELEPHONE NUMBER

ADDRESS (Number and Street) CITY STATE ZIP CODE

9. CASE SETTLED? ☐ Yes ☐ No DATE: Amount: $

10. COMMENTS:

11. THIRD PARTY LIABILITY INSURANCE COMPANY

ADJUSTER'S NAME / TELEPHONE NUMBER

ADDRESS (Number and Street) CITY STATE ZIP CODE

CLAIM / POLICY NUMBER / POLICY HOLDER'S NAME

12 INJURED'S INSURANCE COMPANY

ADJUSTER'S NAME / TELEPHONE NUMBER

ADDRESS (Number and Street) CITY STATE ZIP CODE

CLAIM / POLICY NUMBER / POLICY HOLDER'S NAME

MED PAY ☐ Yes ☐ No

Uninsured/Under Insured Motorist Clam ☐ Yes ☐ No

Policy Limit $ MED Pay Available $

13. PERSON PROVIDING INFORMATION	TELEPHONE NUMBER	DATE COMPLETED

SEE REVERSE FOR INSTRUCTIONS

INSTRUCTIONS FOR USE

This form has been designed to assist law firms, insurance companies and other referral sources to submit notice to the Department of Health Care Services pursuant to Welfare and Institutions Code Section 14124.73, et seq.

Although use of this form is not required, it will expedite the processing of your referral. All notices should contain the following information in printed or typed format.

1. **Name(s) of all Medi-Cal recipients involved (including AKA's). If a minor, the parent's name(s) should also be given. If more than three recipients, attach an additional sheet listing the injurer's information.**

2. **Exact date of injury.**

3. **Social Security number.**

4. **Fourteen-digit Medi-Cal identification number(s). (For example: 10-20-2001346001.) The number may be obtained from the Medi-Cal card or from medical bills paid for by Medi-Cal.**

5. **Date of birth.**

6. **Nature and type of injury. Last date of any known treatment.**

7. **Dental services.**

8. **Attorney name, address, telephone number and firm's name.**

9. **Settlement date and amount.**

10. **Comments. For example, minor's compromise hearing date, trial date, etc.**

11. **Liable third party insurance company name, address, telephone number, claim number, policyholder's name.**

12. **Injurer's insurance company's name, address, telephone number, claim number, policyholder's name, claim type, and policy limit.**

13. **Person providing information.**

Provider information, i.e., inpatient hospital name and date(s) of service may be submitted by attaching an additional sheet. (Copies of bills are NOT requested.)

For specific areas which do not apply, please indicate "N/A" for not applicable.

THIS FORM MAY BE REPRODUCED FOR FUTURE MEDI-CAL REFERRALS